AN ORAL HISTORY OF THE WINFIELD DUNN ADMINISTRATION
INTERVIEW WITH
RICHARD TREADWAY

BY - CHARLES W. CRAWFORD
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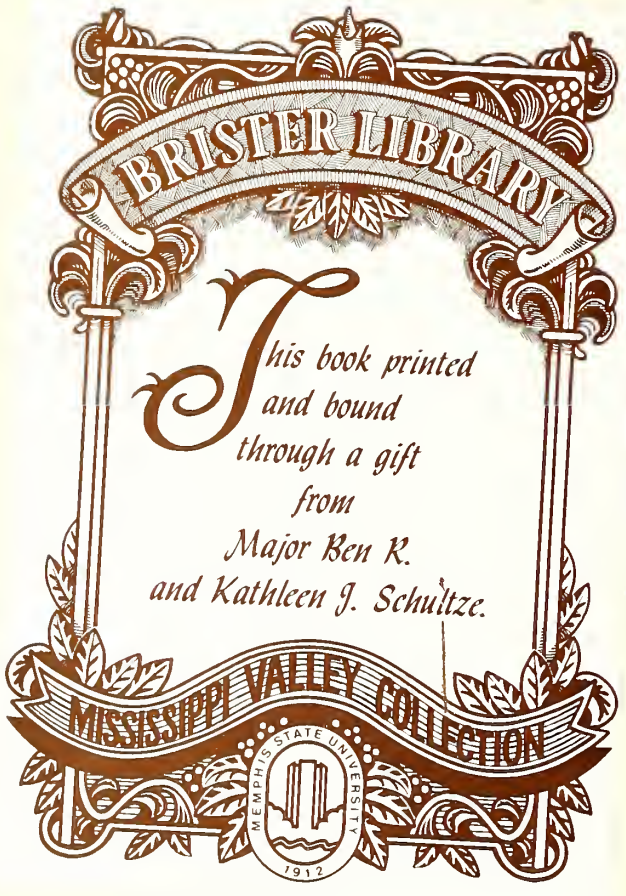
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JUNE 9, 1977

BY CHARLES W. CRAWFORD

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ORAL HISTORY RESEARCH OFFICE

MEMPHIS STATE UNIVERSITY

TREADWAY

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PLACE Nashville, TN.

DATE June 9, 1977

C Richard Treadway, MD
(Interviewee)

Charles W. Crawford
(For the Mississippi Valley Archives of the John Willard Brister Library of Memphis State University)

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THIS IS THE ORAL HISTORY RESEARCH OFFICE OF MEMPHIS STATE UNIVERSITY. THIS PROJECT IS "THE ORAL HISTORY OF THE WINFIELD DUNN ADMINISTRATION." THE PLACE IS NASHVILLE, TENNESSEE AND THE DATE IS JUNE 9, 1977. THE INTERVIEW IS WITH DR. CHARLES RICHARD TREADWAY, FORMERLY COMMISSIONER OF MENTAL HEALTH FOR THE STATE OF TENNESSEE. THE INTERVIEW IS BY DR. CHARLES CRAWFORD, DIRECTOR OF THE MEMPHIS STATE UNIVERSITY ORAL HISTORY RESEARCH OFFICE. TRANSCRIBED BY BETTY WILLIAMS. INTERVIEW # I.

DR. CRAWFORD: Dr. Treadway, I suggest that we start with general biographical information about you up to the point that you became associated with the Dunn Administration.

DR. TREADWAY: Like Governor Dunn, I spent my early childhood in the state of Mississippi. I came to Tennessee to Nashville when I was eleven years old and completed my educational background in Nashville. After graduating from Vanderbilt University as an undergraduate student I attended Vanderbilt School of Medicine and graduated there in 1964. I did my year of internship in internal medicine at Vanderbilt in 1964 and '65. Following that I went to the University of North Carolina at Chapel Hill where I did three years of residency in psychiatry.

I then went to Washington, D.C. where I spent two years in the Public Health Service in order to discharge my obligation to the military. Although I initially entered the Public Health Service as a clinical associate whose assignment was to conduct research in clinical psychopharmocology, it soon became my lot to become involved in administrative matters,

and I was tapped to be a special assistant to the director of the National Institute of Mental Health.

I spent two years in Washington at the National Institute of Mental Health and at the end of that time in 1970, I elected to return to my then home state of Tennessee rather than pursue a career in the federal government although I had a very interesting and intriguing opportunity to do so at that time. When I returned to Tennessee I joined the faculty of Vanderbilt University in the department of psychiatry where I became the director of the Vanderbilt Mental Health Clinic. During that year that I was on the faculty, I was not only involved in administrative and clinical matters, but I prepared for my boards and psychiatry and was able to become board certified in psychiatry.

During the course of that year there was an election. A dentist from Memphis, Winfield Dunn became elected and in January after his election he determined that he would not reappoint the then Commissioner of Mental Health, a good friend of mine, Dr. Frank Lutton. I presumed his primary reason for not reappointing Dr. Lutton at that time was Dr. Lutton's age. Dr. Lutton was in his seventies and Governor Dunn had decided he wanted a younger man who could bring vigor and energy to the department.

I think that perhaps the most difficult thing that faced Governor Dunn at the time was that the law that spelled out the qualifications for commissioner was a rather narrow definition. You had to be 35 years old, you had to be a psychiatrist, you had to have so many years of administrative experience and a number of other qualifications. When the Governor looked around he was unable to find anyone with whom he felt compatible and yet

who met the qualifications of the law.

But during that period of searching he apparently contacted the National Institute of Mental Health and asked them for a recommendation so they then recommended that he contact me since I had worked there fairly recently. The director of the National Institute of Mental Health at that time was my former supervisor, Dr. Bertram S. Brown. So that was how Governor Dunn came into contact with me. Governor Dunn, probably in February or March of 1971, called me down to his office and asked me if I would consider the commissionership if the law were changed which would permit me to serve.

Unfortunately, at the time that we talked I would not have been able to serve because of the statutory limitation--I was only 31 years old at the time and the law required that you be at least 35 years of age. So I did not think seriously that there would be a possibility that I could serve even if I were interested. To be quite candid, I had little interest in a career in government prior to my meeting with Governor Dunn. And this had been something that I had not even contemplated, but I can recall my first meeting with Governor Dunn.

I was so impressed with him as a person, with his forcefulness and his integrity and his personality that I did decide to consider this, not on a permanent basis but on a short-term basis. So to my surprise, several months later, Governor Dunn was able to get the law changed to permit individuals who were 30 years old, or over, to serve as Commissioner, and upon having the law changed, he did in fact offer me the position of Commissioner of Mental Health. And I, after due consideration, did decide

that it would be a rare opportunity and privilege to serve in a cabinet of Governor Dunn. So at the age of 31, I did assume that position and it was a very exciting period for me at that point in my career.

DR. CRAWFORD: What month and year did you become a commissioner?

DR. TREADWAY: I became commissioner six months after he took office--approximately--about 5 1/2 actually. I assumed office on July 1, 1971. So he had been in office about 5 1/2 months before I was able to join him because of the statutory limitations.

DR. CRAWFORD: What situation did you find then when you became Commissioner?

DR. TREADWAY: Well, I think from the standpoint of a department head, one of the things that is very helpful is the awareness and interest of the governor in one's department. There were so many departments so many programs over which a governor presides that it is very difficult to be able, even with an interested governor, to attract the interest of the governor and get him to devote some time to your department as opposed to all the other many departments who also want his time.

But fortunately, for our department, the department caught his attention in a rather inescapeable way within the first week after he was sworn into office and before I even had assumed the commissionership. What happened was: There was a massive expose of Eastern State Psychiatric Hospital in Knoxville within a week or two after he was sworn into office. Of course, none of the blame for the problems that Eastern State had could

be attributed to Governor Dunn. Conditions of filth and mismanagement all sorts of allegations were made and they were made with such publicity and with such public attention that it was difficult for him not to become acquainted rather rapidly with the crying needs of the Department of Mental Health at the time.

DR. CRAWFORD: May I ask further about this expose before we get any further. Do you know who was responsible for that? I remember it well.

DR. TREADWAY: Well, the Superintendent at that time was Dr. Mynatt, Dr. Skip Mynatt. Of course, I would assume, as the chief executive officer of that institution, that he would have to hold some responsibility. Obviously, some of the responsibility has to be shared between the chief executive officer, the commissioner, the legislature which did not appropriate sufficient funds with which to clean the institution. So there is a shared responsibility but I think you can always hold the chief executive officer of the institution accountable first. He left between the time of the expose and the time that I was sworn in. So that be the time that I was sworn in Dr. Mynatt had left and the administrator was still there. So one of my first tasks was to go up and to assess the situation at Eastern State Psychiatric Hospital. Mr. Malone was the administrator at that time. Although it was unclear as to what his responsibilities might have been for some of the conditions that occurred, and what was the responsibility of Dr. Mynatt. There was enough evidence at least as I saw it that new leadership was required and so I did remove Mr. Malone as the administra-

tor.

Another thing that had happened up at Eastern State was that there had been a rather marked emphasis on program as opposed to administration. Not only program but innovative program. There was a fierce pride in being different and being innovative--coming up with new ideas, new concepts that others had not thought about. And as a result they had formed a program which had many promising features, I must confess. It was a psychiatric coordinator's program. The psychiatric coordinator's program had originated as an attempt to deal with the physician shortage at Eastern State. There were very few physicians. So in an attempt to extend the physicians that were available they had created the psychiatric coordinator program. Initially these persons who were to be trained and employed there as psychiatric coordinators were to work under the supervision of the physician as a physician-trained assistant. Unfortunately, as the program developed the role description of these persons became more and more confused and more and more vague.

Rather than have these persons who have had a college education and a little on-the-job training in most instances work under the direct supervision of a more highly trained professional, they became more and more autonomous and more and more independent and in many cases they were beginning to take over the management of the hospital. They were getting orders to the physician, they were giving orders to the nurses and it was really not clear as to who was in charge of what. The nurses were confused whether they or the psychiatric coordinators were responsible for the wards and the physicians were unclear as to what their role was with

the psychiatric coordinators.

It was perhaps a good idea of which had gone sour because of lack of proper delineation of the roles of these individuals. And because of the lack of proper supervision of people who may have been able to make a good contribution had they been able to do so within the proper guidelines. But I thought the situation was rather desperate there. I think when you have a patient who is desperately ill, then you have to engage in heroic measures. You have to take desperate action.

So on my first visit up there I made an assessment of the psychiatric coordinator program and in doing so I concluded that this was a program which had gotten out of hand which had become a monster in a way. So I terminated the program immediately that day. We were able to place the people who were in the program, but we terminated the program--and this was a rather dramatic action. It did cause some concern in the hospital, but at the same time it did show the hospital that we meant business. There was a new management in town, and that we were going to take firm control of the situation and that we were going to delineate responsibilities clearly and that we were going to hold people and programs accountable.

So we did terminate that program which had about 35 people involved, and others who were preparing to become involved. I think that that was probably one of the first actions that we took, other than to terminate the administrator, Mr. Malone. That got the governor's attention so it was an embarrassment to him even though he had no responsibility for the conditions that existed when he came into office. I think he never was

able to lose that interest because he saw that there were problems and that these problems needed a solution. So, although that got his interest initially he never lost his interest and he was committed to the Department of Mental Health from there on.

Another thing that we did as far as Eastern State--and I am spending a little more time on Eastern State because that is where we got started in the Department--and that was the problem that was crying out for the most attention. We had to find new leadership for Eastern State. I think this is one of the issues that relates not only to Eastern State but throughout the department. I am talking about one hospital, but it really applies to the whole system.

One of our primary management goals was a search for quality leadership both programmatically and administratively. So we determined that our first management effort, other than eliminating people and programs that had not proven effective, was to search for new leadership which would bring vigor and determination to Eastern State. So in going over my own ideas about who could assume the position of leadership I went back to people whom I had known in the pase and whom I thought I might have some opportunity to recruit. One of the persons who came to my mind had actually been my boss for awhile in Washington when I spent some time at St. Elizabeth's Hospital during the course of my public health service time.

That was a man named Dr. John Marshall who was at St. Elizabeth's Hospital and who had experience as a psychiatrist, and who had experience both in administration and psychiatric treatment. So I determined after looking at various people that he was the one that I wanted. I talked

with him and I talked with his wife and he had some interest, but his family was in Washington. His wife's family was in Washington. She had absolutely no interest at all in leaving Washington and he was very mild in his expression of interest in coming to Tennessee. But this is an example of how the interest--personal interest--of the Governor can help, because he was obviously the man, but we couldn't recruit him. For one thing the salary that we could pay was inadequate; he would have had to take a substantial salary cut. But with the help of the governor we were able to raise the salary of the superintendent rather dramatically to the point where he would actually not lose money by coming. He would not gain that much, but he would not lose income.

That was one thing that Governor Dunn permitted me to do. I expressed to him my concern that I could hire 5,000 employees at $5,000 or $10,000 a year, but I couldn't hire one at a decent salary. We were not talking about spending more total money, but having fewer people--higher quality people--which was the approach we took. He agreed wholeheartedly with that concept and we were able to get the salary. But I still, even with the salary, I still wasn't getting anywhere. So I had him down along with his wife just for a visit even though we knew he was not interested in coming down to Knoxville. So we had the Mental Health Association who entertained Dr. Marshall and his wife there in a private home and they were gracious to the Marshalls and they were very helpful. This was an example of how a private citizen--the volunteer--who can reach out to people who are contemplating government and assist government in doing its job.

That still didn't do enough although it was helpful. So finally, I wanted to impress upon Dr. Marshall how much we wanted him, how much we would support him and so I was able to convince the governor that this was the man and he really never asked any questions and he had confidence in my judgment. And as a good manager, he said, "This is your department and if you tell me that this is what you need then I will go along with you." So he went along with me to Washington to recruit Dr. Marshall. And I will never forget having breakfast one morning with the Governor and Dr. Marshall in the Washington Hilton.

And the Governor in his usual charming manner assisted me personally in recruiting Dr. Marshall. This was the thing that made the difference. When you are recruited by Winfield Dunn then you certainly have a difficult chance in saying no, as I previously found out. Shortly after this, Dr. Marshall and his wife agreed to come to Knoxville and to assume the leadership of Eastern State Psychiatric Hospital.

Eastern State was basically in a shambles at the time. Within two years after Dr. Marshall came to Eastern State, we had a new administrator to work with Dr. Marshall, we had several new psychiatrists. We had moved all of the patients out of the old unsafe building and that had been torn down. We had cleaned up what we had and had discharged many patients who didn't need to be there and who had been transferred to nursing homes where they could be more suitably cared for.

The census had been cut down by some 800 patients within about a year after he got there.

DR. CRAWFORD: Now, is that at Eastern State?

DR. TREADWAY: Eastern State alone. Within two years they received for the first time ever, accreditation by the joint commission on accreditation of hospitals. So I think that just illustrates the importance of the proper leadership and the enormous value that the personal support of the governor can have in insuring that the proper leadership gets there and then once it gets there is supported in being able to do its job. Eastern State has been accredited since 1973 and largely due to the recruitment of this highly qualified administrator-psychiatrist who was then able to bring in other professional and administrative people to build up the program. It is a fine psychiatric hospital today and is doing an excellent job.

Of course, this same phenomenon occurred throughout the rest of the department.

DR. CRAWFORD: Would you mind listing the other institutions you were in charge of at the time you took over the department?

DR. TREADWAY: Well, we had eight institutions in the Department of Mental Health when I took over and when I left as far as institutions which provided for the long-term care of people who were mentally disabled. We had three mental retardation institutions. They were Clover Bottom--that was the oldest one here in Nashville--out at Donelson. We had Green Valley which was up near Greeneville, Tennessee--up in East Tennessee. Then we had Arlington which was in West Tennessee just outside of Memphis. Then we had five psychiatric hospitals--Central State--the oldest one here in Nashville. We had

Eastern State which was probably the next oldest which was in Knoxville. Then approximately of the same vintage was Western State which was in Bolivar, Tennessee over in southwest Tennessee. Then we had Moccasin Bend which was in Chattanooga. Then we had Tennessee Psychiatric Hospital and Institute in Memphis. Those were the eight institutions where we had over 10,000 patients--this would be my recollection--rough estimate. Actually, we had the largest number of employees of any department of state government in order to care for all of these patients.

We didn't have the largest budget. I guess education probably had the largest budget, but in terms of employees we had the largest department in state government.

We did the same thing in terms of recruiting leadership at Western State. And we were very fortunate there in being able to recruit a man who was a psychiatrist--again who was not only a psychiatrist but he had his masters degree, but the Navy transferred him out of Washington. He was enrolled in Georgetown and he was unable to complete his law degree. He had a tremendous background and he had more than twenty years experience in critical and administrative psychiatry in the Navy. Again the personal interest of the governor in assisting me in recruiting him. Who would have thought that a man with that background would be willing to come to West Tennessee to a small town, isolated from the large metropolitan areas and take over the superintendency of a hospital that was unaccredited and which had many problems. But we were able to recruit Dr. Earle Ninow. He did come down from Philadelphia.

Again, the same story that was at Eastern State. Within two years a

hospital which had never been accredited was fully accredited. Again, this was due to leadership. He was able to bring in licensed physicians, administrators and other people and build a team of managers and leaders in the hospital operating on the concept that we don't want just quantity of people, but we would rather have a few people who are highly qualified and spend the same amount of money on less (employees) than to hire large numbers of people who are less qualified and who are less prepared to do the job that we needed to have done.

DR. CRAWFORD: Did you feel that that had been a problem throughout the department--the hiring of many people at lower salaries, but with less qualifications?

DR. TREADWAY: I think that had been the preoccupation of the state government. There seemed to be little concern about how many employees you had as long as they were not paid too highly. It was far easier to get two employees at $10,000 a year than to get one at $20,000. So I think there was this philosophy that Governor Dunn was responsive for changing this philosophy. In many cases we found that whereas it might have been possible to get two employees at $10,000 a piece that we were able to get one at $18,000 or at $16,000 who could do the job and do a better job than those two working at $10,000. So we made a determined effort to get quality. On the same line we had a terrible problem with the salaries of physicians.

Most of the physicians in the state institutions were unlicensed physicians. They had no license to practice in the state and in a real literal sense the Department of Mental Health was in violation of the very

laws of the state of Tennessee relative to the practice of medicine.

We made the decision that if the state Department of Mental Health doesn't obey the laws of the state of Tennessee, then how can we expect the citizens of the state of Tennessee who are not state employees to obey those laws! Why should the state be exempt from fullfilling the requirements of the law! So we issued a directive--a policy decision--by the department that no further unlicensed physicians were to be employed. Further we issued a directive that in addition to that the unlicensed physicians that we already had employed would have to become licensed by studying for and taking necessary examinations or would have to be discharged from the department or to be reassigned to other duties which would be other than being a full-fledged physician.

DR. CRAWFORD: Why generally were these physicians unlicensed? Were many of them from abroad?

DR. TREADWAY: Many of them were foreign trained. This of course, was a problem because although some of them were very dedicated and were very fine doctors, many of them had difficulty with the language and of course with psychiatric patients which were mentally retarded. There was some difficulty in communication. Not only was there a problem in terms of communication with patients, but in many cases the level of training had been less than desirable and it was not of the same quality as graduates of our medical institutions. And not only that, but [because of] the lack of licenses by these physicians we were not qualified for many federal programs such as Medicare and Medicaid which required licensed physicians. We were also unable to become accred-

ited without having all physicians licensed in the practice of medicine.

So by requiring that we have all licensed physicians for the first time in the Department of Mental Health we were able to qualify for Medicare and Medicaid. And, in fact, in Medicaid alone, whereas we had received almost no Medicaid intermediate monies within four or five years after we became eligible the Department of Mental Health and mental health programs were receiving thirty million dollars in federal Medicaid programs. So this was a dramatic change in the fiscal condition of the mental health department by having spent a small amount of money to pay for higher salaries so that we could get licensed physicians we were able to many times over to compensate for that by receiving millions and millions of federal Medicaid dollars through intermediate care programs which became certified for the first time.

So that this was a tremendous help to us. By the time we left office we were able to get four out of the five psychiatric hospitals that had been inspected by the Joint Commission on Accreditation of Hospitals--four out of five were accredited. We did not receive notification of Western State's accreditation until after Governor Dunn left office but the actual inspection was done in December of 1974 before he left office. Official notification was received shortly after he left office.

Whereas none of the hospitals had been fully accredited before he came into office, four out of five of the psychiatric hospitals were accredited when he left office. That was another goal that we had while we were in office. And that is: To get the institutions accredited. We had to have some kind of standards by which to judge our quality and pro-

gress of our programs. Whereas in the past we had used internal standards which varied from hospital to hospital, from division of the department to division. We said let's look at some national standards and when we looked at the Joint Commission on Accreditation of Hospitals' standards they certainly were high standards. We had to reach very high to reach those standards, but we made an all out committment as a department to achieve the accreditation for all three mental retardation institutions and for the five psychiatric hospitals. And every time we would have department meetings we would stress accreditation. And every month when each hospital and each division filed its report the first thing on the report was where they were in terms of complying with the requirement for accreditation.

I know they became sick every time I would go out, I would say, "How are you doing on your accreditation? Have you made progress? Where are you deficient?"

This was an important tool. Not only did it permit us all to talk the same language and to work together but it permitted us to talk to the Legislature. The Legislature would say, "Why do you think you need these thirty more positions in nursing at Green Valley?"

We could say, "This is required for accreditation, and if we can get accredited then we can get more federal funds. We will know that we are providing quality care."

So the Legislature joined into this joint effort of seeking accreditation. Accreditation means not only a level of staffing program, but it means fire safety. We had to do certain things for fire safety so that we could tell the Legislature. "All right, for accreditation we have to

sprinkle this building. We cannot get accreditation if it is not sprinkled." (This is to have sprinklers in it.)

They would say, "Well, that makes sense." Here we have some national standards and people say that the building is not safe. Obviously, we are concerned about our citizens and we want it to be safe. We are going to appropriate the money for you to buy those sprinklers. And we would get it. During our administration due to the joint support of Governor Dunn first as governor and of the Legislature, we are able to double our budget.

Of course, a substantial part of this increase in budget was from federal funds for which we qualified. So the state did not have to make as massive an increase in our budget as we otherwise would have been required had we not qualified for the federal program. We got excellent support from the Lt. Governor, John Wilder. Lt. Governor Wilder was on our Board of Trustees of our Department of Mental Health. He was very faithful in attending our trustee's meetings, very interested in our programs. And he would go with me on occasion to visit the hospitals. Speaker McWherter was quite interested. When we could sit down and tell them about the problems, then they were quite supportive and quite interested.

I don't want to imply that we were able to achieve all the recruiting that we would have liked to in the department. There were areas where we were not able to recruit the people that we needed to get the job done.

One of these was in the case at Central State--the oldest of the state's psychiatric hospitals--because of salary limitations and because of the age

of the building and because of an assorted collection of problems that had built up over many years. We were unable to recruit the leadership and keep the leadership there that we needed to make the kind of progress that we wanted to move ahead.

We did have one very fine hospital administrator there--Mr. Jim Miller. He was a breath of fresh air there. He would get things done, and we could call the problems to his attention and he would move on them and do things and get people behind him and organized. But unfortunately, he had been there only about nine months when he suddenly became ill with spinal meningitis and died and we lost a very very potent leader at Central State. We never quite fully recovered from that loss.

We were able to make significant gains there at Central State nevertheless in the area of facilities. In fact, the whole facilities of the whole Department of Mental Health were tremendously upgraded over the time that we had. Governor Dunn committed some approximately thirty-five million dollars to upgrade the building and to comply with fire safety and creating new buildings where old buildings had to be torn down, such as at Eastern State where we just had buildings that could not be rendered safe and could not be rendered capable of providing modern humane care. This thirty-five million dollars was largely state funds. They were essential funds.

Generally, I would say that I tend to be fiscally conservative and I do not believe in large-scale government spending, but I think in this case anyone who visited the buildings, which we had at the time he took

office, would have concluded that the physical plant of the Department of Mental Health was deplorable and in terrible shape. Even though undoubtably it was far better than it had been five years ago. Then I am sure that there had been continual improvements over the past twenty years, but there were things like this that need doing that cost money.

There were other things that needed doing that cost no money. In fact, they saved money and improved the program. One of the things had to do with the farms that were operated by the Department of Mental Health. We had eight institutions and I think we had farms at five of those institutions. As a psychiatrist when I came aboard as Department of Mental Health Commissioner I was amazed to learn that we had several thousand acres of farms that were under the management of the Department of Mental Health. I think the Department owns some 8,000 acres at the time and much of that was under cultivation--cotton and corn--and we had the largest cattle herd in the state. I have forgotten whether it was beef or dairy or a combination.

We had a massive farming operation. We had our own farm manager at each institution. We had various farmers, and I tried to understand why we had this farming operation. Apparently, this is what had happened. When the institutions were formed, they were formed with the understanding that they would be self-sufficient. As a result they would attempt to grow their own beef, have their own dairy herd providing milk, grow their own crops to provide food for the table and they would use, as they called them then inmates, to cook the food and to grow the crops and what have you in order to be self-sufficient.

DR. CRAWFORD: Rather similar to the prison system.

DR. TREADWAY: Well, we have come a long way since then, but much more autonomous and self-sufficiency was demanded. So originally, many of the patients a hundred years ago were farmers and when they would come into the hospital and stay long periods of time they enjoyed continuing their occupation as farmers, working on the hospital farm. But gradually as the less ill patients were able to get care in mental health centers and elsewhere, the population at the state hospitals became sicker and sicker and they were less able to work on the farm because then the hospital became reserved for the most ill instead of people who could have been cared for if the community resources had been available.

Another thing is the over the hundred years since the farms had been started the occupations of the general public have changed greatly. Whereas most of the patients a hundred years ago were farmers, only a small proportion of the patient clientele were actually farmers. So we were not able to entice our patients to work out in the hot sun when they were on farms. So we were having to import workers to farm the farm--hire people to farm the farm. We were losing money doing this. In many cases it was costing us more to grow our own crops than the beef from somebody else and to buy the vegetables from somebody else. So we went through and we closed all the farms throughout the state. Where we had the land we leased it out. Of course, the money would come back into the state coffers. Then we were able to convert these employees that had worked on the farm to grounds-keepers and maintenance to help upgrade the deplorable

physical plants and the outside conditions.

One of the things that we were committed to was that one cannot have a good hospital until one has a good hotel. You can't provide good psychiatric care if you have a dirty floor or your yard has not been mowed. So we had the philosophy that before we could have a good hospital we had to have a good hotel. So we tried to devote enough staff and resources to have clean floors and clean sheets and reasonably safe buildings.

Then we would work on the programs and actual professional care, or try to do it simultaneously. This has been the opposite of the philosophy at Eastern State. Eastern State had said we don't have enough resources so they said we are going to spend all of our resources on the program and we are not going to worry whether the windows are broken, whether the floor is dirty, or whether we have rats running around the hospital or roaches in the kitchen. We are just going to worry about the program. We are going to try to help these people talk their problems over and get better.

Well, that kind of philosophy will not work. The public doesn't understand it when they come into the hospital when they see rats running around, see roaches in the kitchen and, of course, the patients don't benefit. They have to have basic humane circumstances--clean rooms and have to feel cared for as far as their basic needs. Then you can move one to provide for their professional psychiatric needs.

But that was our philosophy so with the closing of the farms we were able to use some of those resources to improve the maintenance of the grounds and of the buildings of the state hospitals.

DR. CRAWFORD: Will you comment some, Dr. Treadway, on the type of patient that you had when you became Commissioner, that is, in regard to the severity of their illness? Were you able to transfer some of them elsewhere?

DR. TREADWAY: We had a philosophy that was somewhat different from some of the states. The state of Massachusetts had decided that they were going to close all state hospitals--that state hospitals were no longer needed and that they were an anachronism of the twentieth century and that they should be closed. California was attempting something of the sort. My philosophy was a more moderate one. We felt that indeed there were patients in the mental hospital that didn't need to be there--people who had been ill for a long time and there was apparently no more that could be done for that individual. He was not in need of acute or intensive care and so in many cases we were able to take chronic patients who were fairly well-controlled and to place them in nursing homes and boarding homes.

Of course, it was very difficult to find qualified board homes and nursing homes. There were not perhaps enough state guidelines as to what constituted a qualified nursing home or boarding home, but we approached the thing cautiously and with a lot of social work attention as toward finding adequate placement for the patient. By concentrating on getting people out who could be gotten out, our census did come down steadily during the time that we were in office. I think that it came down to about 40% during the time that we were in office overall.

I know in some institutions it came down even more. For example, at

Eastern State we had about 1800 patients and by the time we had left office I know it was under 1200 patients. So we did see a steady reduction in the census of those institutions. At the same time we tried not to initiate any radical change in the care programs for the patients because we didn't want to get into some of [the] problems that New York State and Massachusetts had had in which patients were dumped out on the community without adequate preparation. Many of these people would end up in circumstances that were certainly far from adequate as to their personal safety, cleanliness and welfare not being attended to. We tried always to make sure that the placement was adequate placement. So we did not place some people who might have been placed in other states because we could not be sure that the placement was adequate.

DR. CRAWFORD: What kind of placement did you secure for them?

DR. TREADWAY: It depended upon the nature of the problem.

For elderly people who were there primarily because they were senile and not because they had psychiatric problems we tended to place them in nursing homes. Of course, there has been a tremendous growth of nursing home programs of the state. This benefitted us in the state hospitals because we had places which were fully qualified, clean, well-kept, well-managed where we could place them. In many cases they were eligible for Medicare or Medicaid to assist with the payments.

In other cases where the people were ambulatory and in good physical health but were mentally still unable to be upon their own but needed more custodial care. Then we tended to place these people in boarding homes or in homes where they could receive custodial care of high quality.

Of course, many, many more people were placed back in their own homes, within their own communities. Our community mental health program received a tremendous boost during the Dunn administration. In fact, the last time I looked at it the Community Mental Health Program Budget expanded by almost 500% during the Dunn administration.

By the time we left office we had a network of comprehensive community mental health centers in every region of the state. In many areas of the state if a person had been in the hospital and was discharged there was no place to go and no place to receive follow-up care. For example, a patient from Greeneville or Rogersville who had been at Eastern State --you couldn't discharge them because there was nobody to follow him when he got out of the hospital. So we were able to improve and extend comcunity care, out-patient follow-up care. For example, we built a new mental health center in Greeneville--The Nolichucky-Holston Mental Health Center. For the first time, Greene County, Hawkins and Hancock County are served with out-patient care for their mental patients who are unable to afford or to obtain psychiatric care.

So this has prevented many patients from having to be hospitalized. And if they do have to be hospitalized it had provided out-patient care which has permitted them to return home much sooner. Of course, the sooner they can get out and return home the greater the chance that they will have a job and family to go back to. Where the individual has been away from home for long periods of time, the family ties may have dissolved and the job is no longer there. He is unused to caring for himself and he has become dependent upon society as a ward of society for the rest of his

life. So certainly it was our hope to get these people back out as quickly as possible.

So we built community mental health centers where there had been none. There were many cities and many counties that had not been served.

DR. CRAWFORD: Do you feel that patients who were placed received adequate care? Do you have to take any back?

DR. TREADWAY: Yes, occasionally, we found patients who did not adjust well to a nursing home or a boarding home. Or, upon occasion, we had thought a boarding home would offer good care, and we were not satisfied with the quality of care that was being provided. So in some instances where this would occur we would take six or eight people back who had been in one boarding home because we were unable to be convinced that our discharged patients were receiving the quality of care. We did attempt to provide follow-up to the patients and generally were convinced in most cases that we had satisfactory placement. We did try to plan these placements carefully before actually putting patients out there. And we attempted to work with the families in order to obtain their involvement in the placement process. Of course, they would report to us if there were problems in the placement and we would follow up on that.

DR. CRAWFORD: Did you find any unusual patterns in mental illness in Tennessee? Was it rather similar to that in other states?

DR. TREADWAY: I think that basically our problems were similar.

We probably are not that different from most other states. I think that we were very fortunate in having one department that was responsible for all mental disabilities. So that in many cases we were able to coordinate some of the programs that we had which would not have been possible in other states. For example, we were able to coordinate resources for alcoholism because alcoholism was a responsibility of the mental health department along with drug abuse and mental retardation and mental illness. Whereas the state had no virtually program for alcoholics and none for drug addicts to amount to anything, we issued an instruction to the hospitals for each of the five psychiatric hospitals to create an alcohol and drug abuse unit. Whereas we had had only twenty beds for alcoholics or drug addicts in the state hospital system, we were able to convert some of the beds (about 250 beds to be exact) to the care of alcoholics and drug abusers. We were also able to obtain funding to assist the community mental health centers to provide specialized programs for alcoholics and drug abusers. We attempted to build upon existing programs wherever possible.

I think we saved the state a lot of money. If we had gone out and set up independent alcoholism hospitals and independent drug abuse programs it would have been far more costly than to do it the way we did [which was] to have alcohol and drug abuse units in the state hospitals to have alcohol and drug abuse out-patient programs in the mental health clinics. I think we have the same problems with alcoholics and drug abusers, mentally ill as most other people.

One other thing that I did not mention: Our state Department of Mental

Health is concerned primarily about public programs for the mentally ill, mentally retarded alcoholics and drug abusers. But obviously, the public hospitals and the publicly supported mental health clinics are not the total mental health delivery system. There are many highly qualified private physicians in the state who everyday are involved with the care of the mentally disabled. There are private psychologists who are involved anf others. We were able to negotiate with the Department of Public Health and with the Medicaid Policy Committee for the first time to permit provate physicians to be reimbursed for psychiatric services. The private physicians had been specifically excluded by state medicaid policy. It was permitted by the federal government, but it was a local option and this state had elected not to include dental or mental health services for private practitioners.

We were able to get that policy amended so that persons who needed mental health care and who were qualified for medicaid could receive that care from a mental health center where one was convenient or from a private psychiatrist or another physician who could provide that care. In many cases this gave the patient an option. The persom might get help from his family doctor for that problem or he might go to a private psychiatrist who was better able to handle his problem--more conveniently located.

So I think the inclusion of the private sector in the delivery of mental health care was certainly an unacclaimed event. There was no publicity surrounding it, but I think that certainly we do not like to think that the mental health delivery system as only a public health system but as a

partnership between the public institutions and the private sector. This country has been strong because of its pluralism, and I think this pluralism has worked well for the mentally disabled in the state of Tennessee. We are very proud that we were able to bring in the private sector into the delivery of mental health care.

DR. CRAWFORD: Thank you, Dr. Treadway.